MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 b

09688

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Anne Arundel
City or town Ferndale, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 Yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Ferndale, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME Mary Augustyniak.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Martin Augustyniak
6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) August 15-1866

8. AGE: Years	Months	Days	If less than one day
81			..... hrs. ..... min.

9. Birthplace Poland. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Balcer Cichocki
13. Birthplace Poland

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mr. Martin Augustyniak
Address Ferndale, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-29-47 (month) (day) (year)
Cemetery or ~~Crematory~~ St. Stanislaus
Location Baltimore, Md.
18. Funeral director George A Weber
Address 705 South Ann Street

19. Nov. 28. 19 47 (Date rec'd by registrar) J. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 19 47, at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 47, to November 19 47 and that I last saw h~~er~~ alive on November 19 47

Immediate cause of death	DURATION
(a) OBSTRUCTION	
(b)	
Due to (c) GASTRIC CARCINOMA	
Due to (d) UNKNOWN.	
Other conditions NONE	

(Include pregnancy within 3 months of death)

Major findings of operations NONE PERFORMED
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Henry J Zaruzas MD
M. D. or other
Address Glen Burnie Date signed Nov 26 19 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PRC

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 6968

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years 3 mos. 19 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital , Crownsville

How long in hospital or institution? 32 years, 3 mos. 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 307 High Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JAMES S. BELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 13, 1896

8. AGE: Years	Months	Days	If less than one day
51	9	23	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Lebanon H. Bell
13. Birthplace: Unknown

MOTHER
14. Maiden name: Margaret
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/12/47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville, Md.

18. Funeral director: Supt. Hospital
Address: Crownsville, Md.

19. 11/12/ 19 47 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5, 19 47 at 8:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41 to Nov. 5, 19 47 and that I last saw him alive on Nov. 5, 1947 19

Immediate cause of death	DURATION
Coronary Occlusion	sudden death
Due to	
Due to	
Other conditions: Schizophrenia, Paranoid Type. Known to us since July 17, 1915 (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Montgomery M. D.

Address: Crownsville, Maryland M. D. or other

Date signed: 11/5/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

09690

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Seven Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edith E. Boettcher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Adolph L. Boettcher

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 28th 1884

8. AGE: Years	Months	Days	If less than one day
63	3	25	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: Wm Mitchell

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Anderson

MOTHER — 15. Birthplace: unknown

16. Informant: Miss E. Elizabeth Boettcher

Address: Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/25/47 (month) (day) (year)

Cemetery or crematory: St. Anne's Cemetery

Location: Annapolis Md.

18. Funeral director: John M. Tayloe

Address: Annapolis Md.

19. Nov. 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 22 1947 at 3 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1947, to Nov 22 1947

and that I last saw her alive on Nov 22 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	10 years
Due to: Arteriosclerosis	10 years
Due to:	
Other conditions: Diabetes Mellitus	1 month

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo C Beard M. D. or other

Address: Annapolis Md Date signed 11-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

PRC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09691

308

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years 10 mos. 5 days

Hospital, institution, or street address where death occurred: Crownsville, State Hospital

How long in hospital or institution? 8 years 10 mos. 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Rose Place (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: FANNIE BOTTS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	NEGRO	MARRIED

6.(b) Name of husband or wife: WILLIAM BOTTS

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years	Months	Days	If less than one day
45	??	??	hrs. min.

9. Birthplace: VIRGINIA (Town, county, and state)

10. Usual occupation: DOMESTIC

11. Industry or business:

FATHER — 12. Name: UNKNOWN

13. Birthplace:

MOTHER — 14. Maiden name: UNKNOWN

15. Birthplace:

16. Informant: HOSPITAL RECORDS

Address: CROWNSVILLE, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/16/47 (month) (day) (year)

Cemetery or crematory: Suburban Cem.

Location: Mt. Winn

18. Funeral director: Jesse Reddin

Address: 578 W. Biddle St.

19. 11/13/ 19 47 (Date rec'd by registrar) E. F. Joyce local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 11, 1947, 6:55 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 6, 1939, to Nov. 11, 1947 and that I last saw her alive on November 11, 1947

Immediate cause of death	DURATION
General Paresis	Known to us since 1/6/1939
Due to:	
Due to:	
Other conditions: General Paresis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenthau M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 11/12/47

M I E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

09692

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Arth - Rt #1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Richard Arnold Bowen

3.(b) Social Security Number: 212-05-5646

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Elizabeth Bowen

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 30th 1894

8. AGE: Years	Months	Days	If less than one day
53	5	29	hrs. min.

9. Birthplace: Calvert Co., Md.
(Town, county, and state)

10. Usual occupation: formerly a lineman

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: Hezekiah Bowen
13. Birthplace: Calvert Co. Md.

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs. R. A. Bowen
Address: Arth - A.A.Co. Md.

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: 11/20/47
(month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis

19. Nov. 20, 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 18th 1947, at 4 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 17 1947 to Nov 18 1947 and that I last saw him alive on Nov 18 1947

Immediate cause of death	DURATION
Coronary Thrombosis	10 hrs.
Due to	
Due to	
Other conditions Chr. Bronchitis	Years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C Bowen
M. D., or other

Address: Annapolis Md. Date signed 11-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


NOV 21 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

108 — 09693 — Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: U. S. Naval Hospital, Annapolis, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New Jersey County: Essex
City or town: Bloomfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 37 Morse Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: N

3.(a) FULL NAME: LINDA BRALEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	infant

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 6, 1947

8. AGE: Years | Months | Days: 3 | If less than one day: hrs. min.

9. Birthplace: Annapolis, Anne Arundel, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: William Walker Braley
13. Birthplace: Pittsburg, Penna.

MOTHER — 14. Maiden name: Jean Julia Duffield
15. Birthplace: Wilkesboro, N. C.

16. Informant: U. S. Naval Hospital
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 12th 1947 (month) (day) (year)
Cemetery or crematory: Naval Cemetery
Location: Annapolis Md.
19. Funeral director: John M. Taylor Est.
Address: Annapolis Md.

19. Nov. 12 47 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-9-47 19 47 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/6/47 19 to 11/8/47 19
and that I last saw her alive on 11/8/47 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other conditions: Pneumonia, lobar	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Nicholas M. Greene
Lt jg. (MC) USNR — M. D. or other
Address: Annapolis, Md. Date signed 11/10/47

Joyce.

09694

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

30d cB 28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 years, 3 months, 13 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 19 years, 3 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland Wash. County:

City or town: Washington D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 486 School Street S.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: WILLIAM BRAWNER

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife: ----------

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
87 ?	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace:

MOTHER — 14. Maiden name: Unknown

15. Birthplace:

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/19/47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Asst Hospital

Address: Crownsville Md

19. Nov 19 1947 E T Joyce Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 15th 1947 at 12:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1940 to November 15th 1947 and that I last saw him alive on November 15th 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Cerebral Arteriosclerosis	Known to us since 8/2/1928
Due to:	
Due to:	
Other conditions: Senile Psychosis	Known to us since 8/2/1928

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.: luetica

Autopsy results: Gumma of the Intestines mesaortitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of:

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 11/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2609

Brawner - William
Admitted August 2, 1928
Died November 15, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09695-21

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Three years.
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 3 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: A.A. Co.
City or town: Pasadena (If outside city or town limits, write RURAL and give nearest town)
Street No. here (If rural, give LOCATION)
2.(a) If veteran, name war: W.W.

3.(a) FULL NAME: Susan Brown

3.(b) Social Security Number: None

4. Sex: F
5. Color or race: White
6.(a) Single, married, widowed, or divorced: ~~Married~~ WIDOWED
6.(b) Name of husband or wife: FRANK J.
6.(c) If alive, give age: D years
7. Birth date of deceased (mo., day, yr.): APRIL 3, 1891
8. AGE: Years: 56 Months: Days: If less than one day: hrs. min.
9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: NONE
11. Industry or business: NONE
FATHER 12. Name: ~~WM~~ WM. BEATTY
FATHER 13. Birthplace: MARYLAND
MOTHER 14. Maiden name: L. SCRIVNOR
MOTHER 15. Birthplace: MARYLAND
16. Informant: MRS. LINNIE M. NEIDERT
Address: PASADENA, P.O.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: NOV. 26 '47 (month) (day) (year)
Cemetery or crematory: MAGOTHY CHURCH CEM.
Location: PASADENA, MD.
16. Funeral director: JOHN F. DENNY, INC.
Address: 715 LIGHT ST -30
19. 11-26 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 22, 1947, at 4:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 22, 1947 to November 22 1947
and that I last saw h[illegible] alive on November 22, 1947

	DURATION
Immediate cause of death: Acute dilatation of the	3 hours
Due to: Heart	
Due to: Coronary Thrombosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other
Address: Annapolis, Md. Date signed: 11/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C9696

93d

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 1

(I)

1. PLACE OF DEATH:

County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, Institution, or street address where death occurred:

#1 Louisa Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. #1 Louisa Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ida Mary Carroll

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widowed

6.(b) Name of husband or wife Francis J. Carroll

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 22 - 1862

8. AGE: Years 85 | Months 6 | Days 30 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation Home Wife.

11. Industry or business Own Home

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Irving D. Harbaugh

Address Stoney Run Road, Hanover, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 24-47 (month) (day) (year)

Cemetery or crematory Cemetery

Location Loudon Park Balto. Md.

18. Funeral director Wm. Cook, Inc.

Address 1217 St. Paul Street

19. Nov. 22 1947 (Date rec'd by registrar) A. W. Hedrick ams. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1947, at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Nov. 21 1947

and that I last saw h alive on Nov. 21 1947

Immediate cause of death	DURATION
Coronis - Vascular Disease	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bale Jr. M.D. M.D. or other

Address Linthicum Date signed 11-21-47

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

1318

09697

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital, Institution, or street address where death occurred:
Emergency Hospt. Annapolis Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 84½ in rear of Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: William Carroll

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single

6.(b) Name of husband or wife: ********** 6.(c) If alive, give age ****** years

7. Birth date of deceased (mo., day, yr.): L 1874

8. AGE: Years: 73 Months: Days: If less than one day: hrs. min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: general utility

11. Industry or business: none

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Mrs Letita Chapman
Address: 129 South St. Annapolis Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof November 14-47 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West St. extd. Annapolis Md.

18. Funeral director: Mrs Charles E. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Nov. 13 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 10 1947, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1947, to Nov 10 1947 and that I last saw him alive on Nov 10 1947

Immediate cause of death	DURATION
Ch. Myocarditis c decompensation	10 days
Due to	
Due to	
Other conditions: Ch. Nephritis; Uremia + Starvation (Include pregnancy within 3 months of death) (Taken up by nurse)	?

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. F. Kilcawans, MD M. D. or other
Address: Annapolis, Md. Date signed 11/12/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

09698

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Anne Arundel

City or town Jessup (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Jessup (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Sarah Frances Clark

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Plummer A. Clark

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 17, 1856

8. AGE: Years	Months	Days	If less than one day
91	5	21	..... hrs. ..... min.

9. Birthplace Jessups, A.A. Co., Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Farm

FATHER 12. Name Isaiah Waters

13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth King

15. Birthplace Annapolis Jct. Md.

16. Informant Elizabeth W. Brown

Address Jessups, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 10, 1947 (month) (day) (year)

Cemetery or crematory Clark Cemetery

Location Fort Meade, Md.

18. Funeral director Ide Witt Donaldson

Address Laurel, Md.

19. Nov 10 1947 (Date rec'd by registrar) Clara Kastle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to Nov 8 1947 and that I last saw h.... alive on Nov 8 1947

Immediate cause of death	DURATION
Bronchopneumonia	3 da
Due to Carcinoma of Cecum	6 Mo
Due to Secondary Anemia	6 Mo
Other conditions Senility	10 Yr

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Edgewood Md Date signed 11/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

09699

Reg. Diat. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years.
Hospital, Institution, or street address where death occurred:
Crain Highway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Anna Dembeck

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife August Dembeck
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1861

8. AGE:

Years	Months	Days	If less than one day
86	?	?	hrs. min.

9. Birthplace Poland, Europe.
(Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business

FATHER
12. Name Frank Belting
13. Birthplace Poland, Md.

MOTHER
14. Maiden name Mary Repbeski
15. Birthplace Poland, Europe.

16. Informant Mrs. Walter Dembeck (son)
Address Severn, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof November 24-47. (month) (day) (year)
Cemetery or crematory Sacred Heart of Mary
Location German Hill Rd - Groceland Park
18. Funeral director Milton Schilling
Address 3914 Hanover St. Balto 25 Md.
19. November 22 19 47 (Date rec'd by registrar) Ida M. Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 19 47, at 5 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 46 to Nov. 15 19 47
and that I last saw h[illegible] alive on 11/15/47 19

Immediate cause of death	DURATION
General arterio-sclerosis	15 yrs.
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Lauber M.D.
M. D. or other
Address Glen Burnie, Md Date signed 11/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

09700

CERTIFICATE OF DEATH

BC Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Chelsea Beach, P.O. Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since May - 1947
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2411 - Annor Court.
(If rural, give LOCATION)
2.(a) If veteran, name war World War 1

3. (a) FULL NAME Robert Edward Dixon, Sr.
3. (b) Social Security Number None.

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Married.
6.(b) Name of husband or wife Mrs. Minnie J. Weber Dixon
6.(c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) July 29 - 1896
8. AGE: Years 51 Months 3 Days 4 If less than one day ... hrs. ... min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Fireman
11. Industry or business City of Baltimore
FATHER 12. Name Clarence J. Dixon
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden name Marguerite Hughes
15. Birthplace Baltimore, Md.
16. Informant Mrs. M. J. Dixon (wife)
Address Chelsea Beach, P. O. Pasadena, Md
17. Burial Date thereof November 6, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Md.
18. Funeral director [signature]
Address 1003 W. Baltimore St.
19. 11/5 19 47 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3rd 1947, at 10.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...
Immediate cause of death Coronary Occlusion — DURATION Sudden
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Pauhe[illegible] Assistant Deputy Medical Examiner M. D. or other
Address Glen Burnie, Md Date signed 11/4/4[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 09701

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Hanover
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Hanover
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Stony Run Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Michael J. Dowgalski

3.(b) Social Security Number: 218-14-6448

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Katherine Dowgalski
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Jany. 11. 1889

8. AGE:

Years	Months	Days	If less than one day
58	10	7	hrs. min.

9. Birthplace: Russia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: general
FATHER 12. Name: John Dowgalski
13. Birthplace: Russia
MOTHER 14. Maiden name: not known
15. Birthplace:
16. Informant: Mrs. Katherine Dowgalski
Address: Hanover, Maryland
17. Burial (Burial, cremation, or removal—Which?) Date thereof Nov. 20, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Brooklyn, Md. R.F.D.
18. Funeral director: Thomas W. Swanton
Address: Glen Burnie, Md.
19. Nov 19 1947 (Date rec'd by registrar) L. J. Doll Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18 1947, at 4 P. M.
21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ Post mortem ~~[illegible]~~ by Examiner Nov. 18, 1947.

	DURATION
Immediate cause of death: Acute Cardiac failure	sudden
Due to: Hypertensive Vascular	
Due to: disease.	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Cathy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 11-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09702

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital Annapolis
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 211 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: FRANCES W. FORD

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Earnest J. Ford
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Dec, 31, 1901

8. AGE:

Years	Months	Days	If less than one day
45	10	28	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: House-wife

11. Industry or business

FATHER
12. Name: Charles Purdy
13. Birthplace: Maryland

MOTHER
14. Maiden name: ~~Lilly H.~~ LILLIE C. FORT
15. Birthplace: BALTIMORE, MARYLAND

16. Informant: Mr. Earnest J. Ford
Address: 211 Main St. Annapapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 - 2 - 47 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Maryland

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Md.

19. Dec. 2, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 29 19 47 at 6 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 19 47, to Nov 29 19 47
and that I last saw h--- alive on Nov 29 19 47

Immediate cause of death	DURATION
Cerebral Hemmhage	18 hrs
Due to Hypertension	Several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE George C Boul M. D. or other
Address: Annapolis Md Date signed 12-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

09763

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 6 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 8 years, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 326 North Pine (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: VIOLA GANS (Gaines)

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: Negro

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): unknown to us - 1897

8. AGE: Years 50 | Months ? | Days ? | If less than one day ... hrs. ... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER 12. Name: Robert Gans

13. Birthplace: Virginia

MOTHER 14. Maiden name: Malinda ?

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/25/47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Cedar Hill, Md.

18. Funeral director: A. Galotas

Address: 915 Druid Hill Ave.

19. 11/26 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23rd 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1941, to November 23 1947 and that I last saw her alive on November 23rd 1947.

	DURATION
Immediate cause of death: Chronic Myorcarditis	about 2 yrs
Due to: Cardio-renal disease	about 2 years
Due to:	

Other conditions: Involutional Psychosis Known to us since 10/1941 (Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of

Where did injury occur? ------------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. (M. D. or other)

Address: Crownsville, Maryland Date signed: 11/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

09704
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Anne Arundel
City or town Pig Point, Bristol P.O., Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 - Fourth Ave. South West
(If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Richard Thomas Greenwell

3.(b) Social Security Number 217-07-5078

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Elizabeth Greenwell
6.(c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) May 7, 1890

8. AGE: Years	Months	Days	If less than one day
57	6	15	...hrs. ...min.

9. Birthplace Bristol (Town, county, and state)
10. Usual occupation Time-Keeper
11. Industry or business Maryland Dry Docks
FATHER 12. Name William C. Greenwell
13. Birthplace Bristol Landing, Md
MOTHER 14. Maiden name Elizabeth Howard
15. Birthplace Calvert Co. Md
16. Interment Elizabeth A. Greenwell
Address 9 Fourth Ave. S.W. Glen Burnie, Md.
17. Burial (Burial, cremation, or removal? Which?) Date thereof Nov. 20, 1947 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie, Md.
18. Funeral director Thomas D. Singleton
Address Glen Burnie, Md.
19. Nov 19 1947 (Date rec'd by registrar) L. J. Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1947 at 11 A M
21. I CERTIFY that death occurred on the date above stated: ~~and I attended deceased from~~ Post-mortem Examination
~~and that I last saw him alive on~~ Nov. 17 1947

	DURATION
Immediate cause of death	
Coronary Thrombosis	Sudden
Due to	
Coronary Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Clatty M.D. Deputy Medical Examiner
Address Annapolis, Md Date signed 11-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

09705

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Neck R. F. D. 3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 yrs.

Hospital, institution, or street address where death occurred:
Annapolis Neck

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Neck A. A. Co. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D. 3
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph London Gross

3.(b) Social Security Number: 220- 24-6920

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Widower

6.(b) Name of husband or wife: ********

6.(c) If alive, give age ***** years

7. Birth date of deceased (mo., day, yr.): March 20, 1891

8. AGE: Years 56 | Months 7 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace: Annapolis Neck A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: None

FATHER
12. Name: John Thomas Gross
13. Birthplace: Prince Fredrick Calvert Co.

MOTHER
14. Maiden name: Julia Anne Duke
15. Birthplace: Prince Fredrick Calvert Co. Md.

16. Informant: Mrs Catherine Carter
Address: Annapolis Neck A. A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof November 11, 1947 (month) (day) (year)

Cemetery or crematory: Annapolis Neck Cemetery

Location: Annapolis Neck A. A. Co. Md.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Nov. 11th 1947 (Date rec'd by registrar) W. J. Bunch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 1947, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1947 to November 8, 1947 and that I last saw h[illegible] alive on November 8, 1947

Immediate cause of death	DURATION
Acute Myocardial Failure	1 day
Due to Acute Myocarditis	8 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. K. P. Richardson M.D.
M. D. or other

Address: 110 - Clay St. Annapolis, Md. Date signed 11/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The date of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

09756

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours

Hospital, Institution, or street address where death occurred: Emergency

How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Eastport (If outside city or town limits, write RURAL and give nearest town)

Street No. 1101 Monroe St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Baby Girl Haire

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 1 1947

8. AGE: Years | Months | Days | If less than one day: 6 hrs. min.

9. Birthplace: Annapolis Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Harold Edward Haire Sr.

FATHER — 13. Birthplace: Newberglen, Indiana

MOTHER — 14. Maiden name: Hazel Virginia Hallock

MOTHER — 15. Birthplace: Annapolis Md.

16. Informant: Harold E. Haire

Address: 1101 Monroe St. Eastport Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov 2 1947 (month) (day) (year)

Cemetery or crematory: Quaker

Location: Edesville Md.

18. Funeral director: F. A. Hardesty & Son

Address: Edesville Md.

19. Nov. 2, 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 1 1947 at 5 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 hrs 19.. to 19..

and that I last saw h.. alive on Nov 1 19 47

Immediate cause of death	DURATION
Atelectasis	6 hr
Due to	
Due to	
Other conditions: 4 twins premature	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George C Burch M. D. or other

Address: Crumpton Md. Date signed: 11-1-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92d 09767

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15

1. PLACE OF DEATH:

County: A A County

City or town: Marley Neck Rd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A A Co.

City or town: Marley Neck Rd

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Kallikas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife: George Kallikas

6.(c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): May 8th 1867

8. AGE:

Years	Months	Days	If less than one day
80	5	28	hrs. min.

9. Birthplace: Estonia (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: John Russo

13. Birthplace: Estonia

MOTHER

14. Maiden name: Rena Rice

15. Birthplace: Estonia

16. Informant: Mrs Mary Birk

Address: Marley Neck Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/10/47 (month) (day) (year)

Cemetery or crematory: Meadowridge Mem.

Location: Washington Blvd

18. Funeral director: John F Kenny Inc

Address: 415 Eight St.

19. 11/10/47 (Date rec'd by registrar) G. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 6th 1947, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 3 1947, to Nov 6 1947

and that I last saw h.e.r. alive on 1947

Immediate cause of death	DURATION
coronary occlusion	
Due to: hypertensive cardio-vascular disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Philip W. Kirsten MD (M. D. or other)

Address: 302 Patapsco Ave Date signed: Nov 9 47

Evidence for the change of date of birth is shown on G 113 12/12/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09708

94a

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all time
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3607 Mohawk Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Howard Clarence Hill

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Cornelia Hill
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Nov. 26 1879

8. AGE: Years: 68 Months: 0 Days: 27 If less than one day: hrs. min.

9. Birthplace: Frostburg Maryland
(Town, county, and state)

10. Usual occupation: social worker

11. Industry or business: Prisoner's Aid Ass'n.

FATHER
12. Name: Thomas Hill
13. Birthplace: County Antrim, Ireland

MOTHER
14. Maiden name: Elizabeth Mason
15. Birthplace: Somerset County, Penna

16. Informant: Mrs. Cornelia Hill
Address: 3607 Mohawk Ave, Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30, 1947 (month) (day) (year)
Cemetery or crematory: All Hallows Cemetery
Location: Davidsonville, Md.

18. Funeral director: Miller & Amoreau
Address: 1510 Liberty Heights Ave.

19. 11/29/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 1947, at 3 30 P. M.

21. I CERTIFY that death occurred on the date above stated: ~~He attended deceased from~~ Postmortem Examination 19... and ~~last saw him alive on~~ 19...

Immediate cause of death	DURATION
Coronary Embolism	Sudden
Due to: Coronary Sclerosis	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffy M.D. Deputy medical Examiner
M. D. or other
Address: Annapolis Md. Date signed: 11-27-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09709

83d

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 25 N. Linden Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John J. Hurley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sue Elizabeth Hurley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 16th 1887

8. AGE: Years	Months	Days	If less than one day
59	11	23	..... hrs. ..... min.

9. Birthplace: Crisfield Md. (Town, county, and state)

10. Usual occupation: Auditor for State Md.

11. Industry or business: Alcohol & Beverage Dept

FATHER 12. Name: William J. Hurley

FATHER 13. Birthplace: Va

MOTHER 14. Maiden name: Mary L. Larson

MOTHER 15. Birthplace: Crisfield Md.

16. Informant: Sue Elizabeth Hurley

Address: 25 N. Linden Ave Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 13-47 (month) (day) (year)

Cemetery or crematory: St Annes Cemetery

Location: Annapolis Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. Nov 12 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 9th 1947 at 10:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 31 1947 to Nov 9 1947

and that I last saw him alive on Nov 9 1947

Immediate cause of death	DURATION
Cardia Vascular Failure	48 hrs
Due to: Hemiplegia Left Side	10 days
Due to: Arterial Hypertension	Several Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Oliver Turner M. D. or other

Address: Clerk of Dis Ct Md Date signed: 11/10/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

CERTIFICATE OF DEATH

09710

Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Shadyside

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred: Home - Shadyside, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Shadyside

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lucy Myra Dermann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

B.(b) Name of husband or wife: Fred W. Dermann

6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.): June 30, 1909

8. AGE:

Years	Months	Days	If less than one day
38	4	23	..... hrs. ..... min.

9. Birthplace: Hyattsville, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: John Bergling

13. Birthplace: Hyattsville Md.

MOTHER

14. Maiden name: Lucy Beall

15. Birthplace: Laurel Md.

16. Informant: Fred W. Dermann

Address: Shadyside, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 11/26/47 (month) (day) (year)

Cemetery or crematory: Congressional

Location: Washington D.C.

18. Funeral director: T. A. HARDESTY & SON

Address: Edgewater. Md

19. NOV 24. 1947 (Date rec'd by registrar) I. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23 1947, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ ..... 19..., to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Acute dilatation of heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchie M.D.

M. D. or other acting M. E.

Address: Annapolis, Md. Date signed: Nov. 23, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09711

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1327 Fremont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: GLADYS JOHNSON # 2

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April, 1, 1909

8. AGE: Years	Months	Days	If less than one day
38	7	28	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: George Johnson
13. Birthplace: Virginia

MOTHER
14. Maiden name: Rachel Green
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/30/47 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem
Location: A. A. Co Md

18. Funeral director: Isaac R Brandon
Address: 1956 W Monty mery St Balto

19. 12/1 19 47 A D Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28th 19 47 at 12:45A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10th 19 47 to November 28 19 47 and that I last saw her alive on November 28th 19 47

Immediate cause of death	DURATION
General Paresis	Known to us since 11/10/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Muncaster M. D.
M. D. or other

Address: Crownsville, Maryland Date signed 11/28/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09712

CERTIFICATE OF DEATH

107

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anna Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 27 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 4 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne

City or town: Joppa
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. # 1, Box 43
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3. (a) FULL NAME: WILLIAM HENRY JOHNSON, jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 12, 1939

8. AGE:

Years	Months	Days	If less than one day
8	---	7	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: William Henry Johnson, sen.
13. Birthplace: Cambridge, Maryland

MOTHER
14. Maiden name: Beatrice Ruff
15. Birthplace:

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec 2, 47 (month) (day) (year)

Cemetery or crematory: Tabernacle

Location: Benson

18. Funeral director: Chas E. Goss

Address: Benson Md

19. 12/ 1947 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 19th 1947, at 6:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 23rd 1947, to November 19th 1947

and that I last saw him alive on November 19th 1947

Immediate cause of death: Broncho- Pneumonia — DURATION: 3 days

Due to:

Due to:

Other conditions: Micro-Cephalic, Spastic Idiot. Known to us since June 23, 1947
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of:

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Sam Augustine M. D.
M. D. or other

Address: Crownsville, Maryland Date signed: 11/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Include even if not age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

M I T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

prc.

09713

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hoppital

How long in hospital or institution? 3 mos. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Marion Station (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Alfred Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1900

8. AGE: Years	Months	Days	If less than one day
47			hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER 12. Name: Alfred Jones

13. Birthplace: Maryland

MOTHER 14. Maiden name: Esther Bevins

15. Birthplace: Maryland

16. Informant: Hsopital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 26, 1947 (month) (day) (year)

Cemetery or crematory: Marion Cemetery

Location: Marion , Maryland

18. Funeral director: George W. Tilghman

Address: Marion, Maryland

19. 12/1/47 (Date rec'd by registrar) 19 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23, 19 47 at 9:55 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 19 47, to November 23 19 47

and that I last saw him alive on November 23, 19 47

Immediate cause of death	DURATION
General Paresis	Known to us 8/12/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Mongeuste M. D.

Address: Crownsville, Maryland M. D. or other

Date signed: 11/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 09714

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville P.O.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred: - - - -
How long in hospital or institution? - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Waterbury
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Frank Kaczynski

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Mary Kaczynski
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Oct. 12 1886

8. AGE: Years	Months	Days	If less than one day
61	1	4	...hrs. ...min.

9. Birthplace: Tarnow Poland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Truck Farm
FATHER 12. Name: Martin Kaczynski
13. Birthplace: Poland
MOTHER 14. Maiden name: Martha Nedka
15. Birthplace: Poland
16. Informant: Mrs. Mary Kaczynski
Address: Waterbury, Crownsville P.O., Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-19-47 (month) (day) (year)
Cemetery or crematory: ST. STANISLAUS
Location: BALTIMORE Md
18. Funeral director: George A Weber
Address: 705 S Amity St
19. 11/17/47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 16 1947, at 7.25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5, 1947 to Nov. 16 1947 and that I last saw h...l.M...alive on Nov. 16, 1947

	DURATION
Immediate cause of death: Acute Cardio-vascular failure	sudden
Due to: Auricular Fibrillation	11 days
Due to: Chronic myocarditis	1 year
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M Caffrey M.D.
M. D. or other
Address: Annapolis, Md Date signed: 11-16-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09715

CERTIFICATE OF DEATH

Reg. Diat. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Near Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Near Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eloise Browning Kramer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Kramer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 5, 1870

8. AGE:

Years	Months	Days	If less than one day
77	6	1	..... hrs. ..... min.

9. Birthplace: Laurel Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER

12. Name: John Browning

13. Birthplace: Unknown

MOTHER

14. Maiden name: Mary Matthews

15. Birthplace: Virginia

16. Informant: Mrs. Jack Kramer

Address: 331 Prince George St Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 12/47 (month) (day) (year)

Cemetery or crematory: Greenhill

Location: Laurel Md.

18. Funeral director: Robt. W. Donaldson

Address: Laurel Md.

19. Nov. 11 1947 (Date rec'd by registrar) Clara Kastle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1947, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 1947, to Nov 9 1947 and that I last saw h... alive on November 9 1947

Immediate cause of death	DURATION
Coronary thrombosis	2 wk
Due to	
Due to	
Other conditions: Hypertension	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S McCreary M.D. M.D. or other

Address 701 Main St Laurel Md Date signed 11/9/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ... is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

09716 21

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since two years

Hospital, institution, or street address where death occurred:

Crownsville, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Crownsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. - -

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: KRALL , Hedwig

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Adolf Krall, deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1875

8. AGE: Years	Months	Days	If less than one day
72	-	7	..... hrs. ..... min.

9. Birthplace: Brody, Poland (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: unknown

13. Birthplace: Poland

MOTHER — 14. Maiden name: unknown

15. Birthplace: Poland

16. Informant: St. Klinger, M.D.

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-28-47 (month) (day) (year)

Cemetery or crematory: Rosedale

Location: Phila Rd & Hamilton Ave

18. Funeral director: Jack Lewis, Inc

Address: 200 Eutaw Place

19. 11-28-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 27 19 47 at 9,20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27 19 47 to Nov. 24 19 47 and that I last saw her alive on

	DURATION
Immediate cause of death: Coronary occlusion	immediate death
Due to: Chronic myocarditis	years
Due to: Arteriosclerosis	"
Other conditions: Diabetes mellitus	"

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Hans Meyer, M.D. M. D. or other

Address: Crownsville, Md. Date signed Nov. 27, 47.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 09717

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months 5 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 2 months 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 364 W Biddle Street

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Ella Long

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	negro	Widow

6.(b) Name of husband or wife: Stephen

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	2	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: domestic

11. Industry or business

FATHER — 12. Name: Jacob Banks

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Ardelia Gibings

MOTHER — 15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 29, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore, Md.

18. Funeral director: Wm. Chas. H. Holland

Address: 1631 Druid Hill Ave.

19. 11/29/47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27th 1947, at 12 25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 22 1947, to November 27 1947

and that I last saw h[er] alive on November 27 1947

Immediate cause of death: General paresis — DURATION: known to us since 9-22-47

Due to:

Due to:

Other conditions: Arteriosclerotic Heart Disease — known to us since 9-22-47

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: Crownsville State Hospital Date signed: Nov 25 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10666

Long - Ella

Admitted September 22, 1947

expired November 27, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 BC 09718

Reg. Diat. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 13 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1120 W. Lexington
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME IGNATIUS LYLES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Mery
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 72 | Months ? | Days ? | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Oscar Lyles
13. Birthplace Maryland

MOTHER
14. Maiden name Jane Young
15. Birthplace Maryland

16. Informant Hospital Records
Address Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/3/47 (month) (day) (year)
Cemetery or crematory mt Auburn
Location md.
18. Funeral director Geo. B. Kelson
Address 1303 Pressman St

19. 12/2 1947 L.D. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26th 1947 at 5:15A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13th 1947, to November 26 1947 and that I last saw him alive on November 26th 1947

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 10/13/47
Due to	
Due to	
Other conditions Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 10/13/47

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ---------- Date of .....
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE Jacob Mongenstern M.D.
M. D. or other
Address Crownsville, Maryland Date signed 11/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09719

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days.

Hospital, institution, or street address where death occurred: Emergency Hospital, Annapolis

How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Edgewater P.O.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: A. A. County Home
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Andrew Maker (alias) Wm. N. Markall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	unknown

6.(b) Name of husband or wife: "

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1886

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
61	—	—		

9. Birthplace: Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace:

MOTHER
14. Maiden name: unknown
15. Birthplace:

18. Informant: William A. Jackson
Address: 916 Penna. Ave.

17. Burial — Date thereof: 12-1-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Maryotby

Location: Anne Arundel Co. Md.

18. Funeral director: William A. Jackson

Address: 916 Penna. Ave. Balto. 1.

19. 12/1 1947 A. W. Hedrick DR
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 27 1947, at 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 15 1947 to Nov 27 1947

and that I last saw him alive on Nov 27 1947

Immediate cause of death	DURATION
Chr. Myocarditis c dementia	yrs.
Due to:	
Due to:	
Other conditions: Bilat. Absolute Glaucoma	yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. J. Klawans, M.D.
M. D. or other

Address: Annapolis, Md. Date signed: 11/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

09720

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 55 College Creek Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 55 College Creek Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Infant Mc Gowan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 29, 1947

8. AGE: Years | Months | Days | If less than one day: 13 hrs. ..... min.

9. Birthplace: Annapolis, Md. A.A.Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Jarome Mc Gowan
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Carry Ross
15. Birthplace: Annapolis, Md.

16. Informant: Carry Mc Gowan
Address: 55 College Creek Terrace

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 1, 1947 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis, Md.

18. Funeral director: Annie A. Johnson

Address: Annapolis, Md. P.O. Box 462.

19. Dec. 1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29 1947, at 4 50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 29 1947 to Nov 29 1947 and that I last saw her alive on Nov 29 1947

Immediate cause of death	DURATION
asperation Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. T. Talen M D
M. D. or other

Address: 17 Carroll Date signed: 12-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09721

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A.

City or town Ferndale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Ferdinand ave -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Ferndale

(If outside city or town limits, write RURAL and give nearest town)

Street No. #1 - Ferdinand Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nanoi Carroll Meseke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married -

6.(b) Name of husband or wife Wm E. Meseke

8.(c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Feb. Sept. 20. 1896

8. AGE: Years	Months	Days	If less than one day
51	1	8	....hrs. ....min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation Home wife -

11. Industry or business

FATHER 12. Name Oliver Thomas Douglas

13. Birthplace Va

MOTHER 14. Maiden name Henrietta C. Reeside

15. Birthplace Baltimore Md.

16. Informant Wm. E. Meseke

Address 1 Ferdinand Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-11-47 (month) (day) (year)

Cemetery or crematory Glen Haven Ave.

Location Ritchie Highway

18. Funeral director Geo. H. Lembrich

Address 725 N. Lyndhurst St.

19. 11/10 1947 A. W. Hedrich Registrar

(Date rec'd by registrar)

JC

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1947 at 5:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 5 1947 to Nov. 7 1947

and that I last saw h alive on Nov. 7 1947

Immediate cause of death	DURATION
cerebral Hemorrhage	2 days
Due to Arteriosclerosis -	
Due to	
Other conditions Hypertension -	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bagley, Jr. M.D. M. D. or other

Address Linthicum Date signed Nov. 7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

09722

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

517 Sixth St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 Sixth St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nettie J. Miller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Charles E. Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 28th 1887

8. AGE: Years	Months	Days	If less than one day
60	7	0	..... hrs. ..... min.

9. Birthplace: Sparta, Illinois

(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: —

FATHER

12. Name: William Hart

13. Birthplace: Illinois

MOTHER

14. Maiden name: Alice Redpath

15. Birthplace: Illinois

16. Informant: Charles E. Miller

Address: 517 6th St. Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/1/47 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial Pk.

Location: Glen Burnie, Md.

18. Funeral director: John M. Payton, Son

Address: Annapolis, Md.

19. Dec. 1, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1947 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 1947, to Nov 28 1947

and that I last saw her alive on Nov 28 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	4 hrs
Due to: Hypertension	12 Yrs
Due to:	
Other conditions: Arteriosclerosis	12 Yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Boast M. D. or other

Address: Annapolis Md Date signed 12-1-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

09723

Reg. Diat. No. 21

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 407 Third Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Anna Barbara Mitchell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: John L. Mitchell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 8th 1889

8. AGE: Years: 58 Months: 5 Days: 6 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: William Pilty

13. Birthplace: unknown

MOTHER

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: John L. Mitchell

Address: 407 3rd St. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11/17/47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis

19. Nov. 17 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14 1947, at 3:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 7 1947 to Nov 14 1947 and that I last saw h[illegible] alive on Nov 14 1947

Immediate cause of death	DURATION
Myocarditis acute	1 wk
Due to: Bronchial asthma	4 yrs
Due to:	
Other conditions: Chr. nephritis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C. Boerl M. D. or other

Address: Annapolis Md Date signed: 11-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

BC 09724

CERTIFICATE OF DEATH

Reg. Diat. No. 22

1. PLACE OF DEATH:

County Anne Arundel

City or town Jessup
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Maryland House of Correction

How long in hospital or institution? Since Oct 17-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1203 Valley St.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME William Mullen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1892

8. AGE: Years 54 | Months 11 | Days 29 | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Waiter Tender

11. Industry or business

FATHER
12. Name Thomas Mullen
13. Birthplace Balto. Md.

MOTHER
14. Maiden name Mary E. Watts
15. Birthplace Balto. Md.

16. Informant Mrs. Robert Mullen

Address 1205 Wilcox St

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-19-47 (month) (day) (year)

Cemetery or crematory New Cathedral

Location Old Frederick Rd. Balto. Md.

18. Funeral director Edward H. Conkling & Son

Address 2246 Eager St. Balto. Md.

19. Nov 16 1947 (Date rec'd by registrar) Clara Kaslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1947, at 12.05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 12 1947, to Nov 16 1947 and that I last saw him alive on Nov 15 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Cirrhosis - Alcoholism	?
Due to:	
Other conditions: Chronic Alcoholism, Myocarditis	? ?

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Leroy Wright M. D. or other

Address Jessup Md. Date signed Nov. 16 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1647

CERTIFICATE OF DEATH

BC 09725

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale Beach Chesapeake Bay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1609 East 31st
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME Frank T. Murray

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of ~~husband or~~ wife: MINNA DIETHER MURRAY
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years	Months	Days	If less than one day
63			hrs. min.

9. Birthplace: BALTO. —
(Town, county, and state)
10. Usual occupation: SALESMAN —
11. Industry or business: HATS CLOTHING
FATHER 12. Name: JAMES MURRAY
13. Birthplace: (?).
MOTHER 14. Maiden name: JANE CONCANNON
15. Birthplace: IRELAND.
16. Informant: MRS. FRANCIS T. MURRAY
Address: 1609 E. 31st St. —
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-20-47 (month) (day) (year)
Cemetery or crematory: CATHEDRAL.
Location: CITY
18. Funeral director: WIEDEFELD & SON
Address: GREENMOUNT AVE & 22ND
19. 11/18 (Date rec'd by registrar) 19 47 D.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 14 19 47 at about 8 45 P. M.
21. I CERTIFY that death occurred on the date above stated ~~at the hour stated above~~
Postmortem Examination.
~~Attended deceased from~~ Nov. 16 19 47

Immediate cause of death	DURATION
Suicide by.	
Due to: Drowning	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 11-16-47
Where did injury occur? Chesapeake Bay At Maryland
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): 5 miles off Deale
Means of injury: Drowning Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 11-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 8-45-15

University 2414.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09726

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 1 day
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arund'l
City or town: Centerville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: NEWMAN - ISIAH

3.(b) Social Security Number:

4. Sex	5. Color or race	B.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: ~~Unknown~~ Bertha Newman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
62	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: Isiah Newman
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-3-47 (month) (day) (year)
Cemetery or crematory: Kennedy Neck
Location: near Centerville Md
18. Funeral director: Edgar L. Lane
Address: Church Hill Md

19. 12/2 1947 (Date rec'd by registrar) Edgar L. Lane per T Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 30th 19 47, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 29th 1947, to November 30th 47 and that I last saw him alive on November 30th 1947

Immediate cause of death	DURATION
General Paresis	Known to us since Oct. 29, 1947
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Jacob Marquarten M.D. M. D. or other
Address: Crownsville, Maryland Date signed: 11/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M


RECEIVED
DEC 5 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

09727

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

U.S.Naval Hospital, Annapolis, Maryland

How long in hospital or institution? Dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 49 Amos Garrett Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war: W.W. I

3.(a) FULL NAME: Harry Edwin NEWTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Joerres Augusta Newton (wife)

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 20, 1893

8. AGE: Years	Months	Days	If less than one day
54	6	8	..... hrs. ..... min.

9. Birthplace: Annapolis, Anne Arundel, Maryland (Town, county, and state)

10. Usual occupation: Plumber, Foreman Mech.

11. Industry or business: Civil Service (U.S.Naval Academy)

FATHER — 12. Name: John Henry Newton

FATHER — 13. Birthplace: Cambridge, Massachusetts

MOTHER — 14. Maiden name: Mary Ellen Basil

MOTHER — 15. Birthplace: Annapolis, Maryland

16. Informant: John Henry Newton (father)

Address: 114 Archwood Avenue, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-1-47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis, Md.

18. Funeral director: Benjamin HOPPING and Son

Address: West Street, Annapolis, Md.

19. Dec. 1, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 November 1947 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 November 1947 to 28 November 1947 and that I last saw him alive on 28 November 1947

Immediate cause of death	DURATION
Pulmonary Edema	
Due to: Arteriosclerotic Cardiovascular Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: mate Pulmonary Edema; Cardiac & Aortic Athero-

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Claffy M.D. DEPUTY John M. CLAFFY Medical Examiner. (M. D. or other)

Address: Annapolis Md. Date signed: 11-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09728

61

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Epping Forest. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Epping Forest. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Pauline Pfeffer

3.(b) Social Security Number

4. Sex F
5. Color or race W.
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Ernest E. Pfeffer
6.(c) If alive, give age ___ years
7. Birth date of deceased (mo., day, yr.) Dec 13th 1883
8. AGE: Years 63 Months 10 Days 22 If less than one day ___ hrs. ___ min.
9. Birthplace Wisconsin (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Henry Plank
13. Birthplace Germany
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Mrs Gladys Barry
Address Epping Forest. A.A.Co. Md.
17. Cremation Date thereof Nov 6th 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln
Location Prince Geo. Co. Md.
18. Funeral director John M. Taylor-Son
Address Annapolis Md.
19. Nov. 6, 1947 E. J. Joyce Lowe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4th 1947, at 6 A. M.
21. I CERTIFY that death occurred on the date above stated; ~~I attended the deceased~~ Postmortem Examination ~~I last saw h. alive on~~ Nov. 4, 1947

Immediate cause of death	DURATION
Diabetes mellitus	unknown
Due to Diabetic Coma	several hours
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address Annapolis Md Date signed 11/4/47

STATE OF MARYLAND—CERTIFICATE OF DEATH

09729

92d

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 23-

Village or City Glen Burnie - No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foraign birth? yrs. mos. ds.

2. FULL NAME Robert Ridgley Richardson. If U. S. Veteran, specify WAR —

(a) Residence: No. 413 3rd Ave. S.W. St., Ward —

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Carolen Richardson.

6. DATE OF BIRTH (month, day, and year) Nov 25, 1879-

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	11	29.	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Printer (Retired)

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Printing

10. Date deceased last worked at this occupation (month and year) Retired 10 yrs.

11. Total time (years) spent in this occupation All my life

12. BIRTHPLACE (city or town) Baltimore, Md. (State or country)

FATHER

13. NAME Robert Richardson.

14. BIRTHPLACE (city or town) Baltimore, Md (State or country)

MOTHER

15. MAIDEN NAME Laura Jackson.

16. BIRTHPLACE (city or town) Baltimore, Md (State or country)

17. INFORMANT Mrs Carolen Richardson. (Address) Glen Burnie Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Woodlawn Cem Date May 26, 1947

19. UNDERTAKER Thomas W Douglas (Address) Glen Burnie Md

20. FILED 11/25, 1947 J. J. D'Alba Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Nov 23, 1947 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attendad deceased from Jan., 1946, to Nov 23, 1947.

I last saw h.im alive on Nov 23, 1947; death is said to have occurred on the date stated above, at 10 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importanca ware as follows:

	Date of onset
Chronic Valvula Disease of the Heart	44 yrs.

Other **Contributory Causes** of Importance:

Name of operation None Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was dua to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, spacify —

(Signed) James S. Ballentine. M. D.

(Address) Glen Burnie. Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car NOV 28 1927	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09730

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Months 4 Days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 5 Months 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2243 Brunt Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HARRY S. ROBERT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Nancy Robert
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown to us 1887

8. AGE: Years	Months	Days	If less than one day
60?	?	?	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business:

FATHER
12. Name: James Robert
13. Birthplace: Unknown to us

MOTHER
14. Maiden name: Caroline Jackson
15. Birthplace: Unknown to us

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal): Date thereof: Dec 4 1947 (month) (day) (year)
Cemetery or crematory: Certain Stat cem.
Location:

18. Funeral director: Mrs Kate R. Williams
Address: 322 N. Schroeder St.

19. 12/4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29, 1947 at 7:58 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 25, 1947 to November 29 1947 and that I last saw him alive on November 29, 1947

Immediate cause of death	DURATION
General Paresis	
Known to us since	June 25, 1947
Due to	
Known to us since	
Due to	
Other conditions: Generalized and Cerebral Arteriosclerosis	June 25, 1947

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Jacob Mongerson M. D.
M. D. or other
Address: Crownsville, Md. Date signed: 11/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Rec'd
US
12/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

S-09731

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Washington, D.C. County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2007 Rosedale Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: CURTIS N. ROBINSON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Lula N. Robinson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ? 1920

8. AGE:

Years	Months	Days	If less than one day
27	?	?	hrs. min.

9. Birthplace: Texas
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Quille Robinson
13. Birthplace: India

MOTHER
14. Maiden name: Anitta Narciene
15. Birthplace: Cuba

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 11 (month) 29 (day) 47 (year)

Cemetery or crematory: Payne Cem

Location: Washington D.C.

18. Funeral director: Hall Bros.

Address: 621 Fla ave NW Wash DC

19. 11/29 (Date rec'd by registrar) 47 E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 26th 1947, at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28th 1947, to November 26th 1947 and that I last saw h... im... alive on November 26th 1947

Immediate cause of death	DURATION
General Paresis	Known to us since 10/28/47
Due to:	
Due to:	
Other conditions: General Paresis	Known to us since 10/28/19 47

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of:

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquette M.D.
M. D. or other

Address: Crownsville, Maryland Date signed: 11/26/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1314a D 09732

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Florida County:

City or town: St. Petersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 238 6th Ave. NE
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Emma C. Rogers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Frank Rogers

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1884

8. AGE: Years	Months	Days	If less than one day
62	11	4	____ hrs. ____ min.

9. Birthplace: C. A. Co. Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: Thomas Crandell
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary Hertzog
15. Birthplace: unknown

16. Informant: Frank A. Rogers
Address: St. Petersburg, Fla.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/13/47 (month) (day) (year)

Cemetery or crematory: Greaken Burial Ground

Location: Galesville, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis

19. Nov. 12 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11 1947, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 26 1947 to Nov. 10 1947 and that I last saw her alive on Nov. 10, 1947

Immediate cause of death	DURATION
Toxemia	
Due to: Pyonephrosis	12 days
Due to: Nephrolithiasis	3 mos.
Other conditions	5 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury: ____ Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D.
M. D. or other

Address: Annapolis, Md. Date signed Nov. 11, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

182

09733

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Patapsco Park P.O. Baltimore Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 days.

Hospital, institution, or street address where death occurred: ~~Box 3 194~~ 201 - Bishop Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: (If outside city or town limits, write RURAL and give nearest town)

Street No. Same

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Patrick John Royster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Black	Single.

8.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Nov. 3 - 1947

8. AGE:

Years	Months	Days	If less than one day
		17	hrs. min.

9. Birthplace: University Hosp. Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER

12. Name: Early Royster

13. Birthplace: Virginia.

MOTHER

14. Maiden name: Annie Virginia Beadeland

15. Birthplace: Severn, Md.

16. Informant: Mrs. Early Royster (mother)

Address: 201 - Bishop Ave. Patapsco Park, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov 21 - 47 (month) (day) (year)

Cemetery or crematory: Hammon.

Location: A.A. Co. - Md.

18. Funeral director: James A. Stamps

Address: 1142 W. Fayette St.

19. 11/20/47 (Date rec'd by registrar) H.D. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 19 47, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ——— 19—, to ——— 19—

and that I last saw him alive on ——— 19—

Immediate cause of death	DURATION
a. asphyxia -	Sudden.
Due to (sleeping with his mother.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident. Date of 11/20/47

Where did injury occur? Patapsco Park. A.A. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home.

Means of injury? Slept with mother Injured at work? No

23. SIGNATURE Gustave W. Pembert M.D.
Acting Deputy Medical Examiner, M. D. or other

Address: Glen Burnie, Md. Date signed 11/20/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Hawkins.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51b 09734

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Spa Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Spa Road, Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 53 Spa Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Gabriel Scott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary E. Scott
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 19, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	13	..... hrs. ..... min.

9. Birthplace: A.A? Co. Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: James Scott
13. Birthplace: Md.

MOTHER
14. Maiden name: Eliza Duckett
15. Birthplace: Md.

16. Informant: Mary E. Scott
Address: 53 Spa Road, Annapolis, Md.

17. (Burial, cremation, or removal. Which?): Burial
Date thereof: Nov. 16, 1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis, Md.

18. Funeral director: J.B. Johnson
Address: Annapolis, Md. P.O. Box 462

19. Nov. 14, 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 13, 1947, at 6:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4, 1947, to Nov 13, 1947 and that I last saw h... alive on Nov 10, 1947

Immediate cause of death	DURATION
Carcinoma of prostate & metastasis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W.K. Hawkins M.D. M. D. or other
Address: 31 Francis Street Date signed: 11/14/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09735

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CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Galesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Galesville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) —
2.(a) If veteran, name war

3.(a) FULL NAME John Scott

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 2. 1947

8. AGE: Years — Months 10 — Days 13 — If less than one day ..... hrs. ..... min.

9. Birthplace Galesville Md. (Town, county, and State)

10. Usual occupation

11. Industry or business

FATHER 12. Name Reginal Scott
FATHER 13. Birthplace Brandywine

MOTHER 14. Maiden name Viereta Medley
MOTHER 15. Birthplace Brandywine

16. Informant Reginal J. Scott
Address Galesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof NOV 13-47 (month) (day) (year)
Cemetery or crematory St Marys Cem
Location Pisscataway Md

18. Funeral director W. C. Stanley & Son
Address Galesville Md

19. 11/13 1947 (Date rec'd by registrar) W. R. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1947, at 2 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 8, 1947, to November 12 1947 and that I last saw h.... alive on November 12, 1947

Immediate cause of death	OURATION
Bronchial Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. H. Johnson M. D. M. D. or other
Address 40 Northern Street Date signed 11/12/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

pc 09736

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: 936 Druid Hill Ave.
(If outside city or town limits, write RURAL and give nearest town)

Street No. ____
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: SMITH - VIOLET

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years	Months	Days	If less than one day
50			____ hrs. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: —

FATHER
12. Name: Unknown
13. Birthplace: —

MOTHER
14. Maiden name: Unknown
15. Birthplace: —

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Cedar Hill, Md.

18. Funeral director: A. Halstead

Address: 918 Druid Hill Ave.

19. Nov. 28, 19 47 (Date rec'd by registrar) A. W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 19 47 at 5:30a. M

21. I CERTIFY that death occurred on the date above stated; that I last saw deceased on November 17 19 47 and that I last saw him alive on November 25 19 47

Immediate cause of death: Psychosis with cardio renal disease — DURATION: Known to us since 11/17/47

Due to: ____

Due to: ____ — DURATION: Known to us since 11/17/47

Other conditions: Cardio renal disease

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Jacob Morgenstern M. D. M. D. or other

Address: Crownsville, Maryland Date signed: 11/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9Ha

CERTIFICATE OF DEATH

Reg. Diat. No. 09737

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 304 N. Glen Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Murray S. Sweeney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Frances Sweeney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 22d 1887

8. AGE: Years	Months	Days	If less than one day
60	10	2	hrs. min.

9. Birthplace: Athens, Ohio
(Town, county, and state)

10. Usual occupation: Chief Engineer at

11. Industry or business: Annapolis Dairy

FATHER
12. Name: Michael Sweeney
13. Birthplace: Ohio

MOTHER
14. Maiden name: Katherine Mallen
15. Birthplace: Ohio

16. Informant: Mrs. Frances Sweeney
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 26 49 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial

Location: Glen Burnie Md.

18. Funeral director: John M Tayloe Jr

Address: Annapolis, Md.

19. Nov 25 19 47 (Date rec'd by registrar)

S Bowerman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 1947 at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 23 1947, to Nov. 24 1947 and that I last saw h.. alive on Nov. 24 1947

Immediate cause of death	DURATION
Coronary occlusion	6 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S Bowerman M.D.
M. D. or other

Address: Annapolis Md. Date signed: 11/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09738

93d

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: West Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Nospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Weems Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Franklin Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elizabeth V. Thomas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 24, 1874

8. AGE: Years: 73 | Months: 11 | Days: 15 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pri Geo Co Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: boat-building

FATHER 12. Name: John Frank Thomas

FATHER 13. Birthplace: Md.

MOTHER 14. Maiden name: Margaret Moore

MOTHER 15. Birthplace: Md.

16. Informant: Mrs. Elizabeth V. Thomas

Address: Weems Creek West Annapolis, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 11-11-1947 (month) (day) (year)

Cemetery or crematory: St Mary's

Location: Annapolis Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis Md.

19. Nov. 10 1947 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 8 19 47 at 5 30 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post-mortem Examination ~~to~~ Nov. 8, 19 47 ~~and that I last saw him alive on~~

Immediate cause of death	DURATION
Cardio-vascular failure	duration
Due to: Chronic myocarditis	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Cathy M.D. Deputy Medical Examiner M. D. or other

Address: Annapolis, Md. Date signed: 11-8-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09739

111a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Oakwood, Glen Burnie, P.O., Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 31 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Oakwood, (Glen Burnie, P.O.)
(If outside city or town limits, write RURAL and give nearest town)

Street No. Oakwood Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Veronika Tores

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Adolph Tores

6.(c) If alive, give age: Deceasrd years

7. Birth date of deceased (mo., day, yr.): August 20, 1893

8. AGE: Years	Months	Days	If less than one day
54	3	9	..... hrs. ..... min.

9. Birthplace: Austria Hunguary
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Own Home

FATHER
12. Name: Mathias Till
13. Birthplace: Austria Hunguary

MOTHER
14. Maiden name: Elizabeth (Unknown)
15. Birthplace: Austria Hunguary

16. Informant: Mrs. Gertrude Ruskie
Address: Oakwood; Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 2, 1947 (month) (day) (year)

Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 12/1 19 47 (Date rec'd by registrar) L. J. Dalba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 29, 1947, at 8.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 1946, to NOVEMBER 1947 and that I last saw h[illegible] alive on Nov. 29 1947

Immediate cause of death	DURATION
PULMINARY INFARCT	
Due to: UNKNOWN - POSSIBLE VALVULAR VEGETATION	
Due to:	
Other conditions: ACUTE CHOLECYSTITIS AND HYPERTENSION	

(Include pregnancy within 3 months of death)

Major findings of operations: NONE Date of op.

Autopsy results: NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. F. Zangara, M.D. M. D. or other

Address: Glen Burnie, Md. Date signed: Dec 4, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10504

61

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: 81, West St
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Margaret A. Sydnor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John W. Sydnor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 2nd 1872

8. AGE: Years: 75 | Months: 7 | Days: 4 | If less than one day: ..... hrs. ..... min.

9. Birthplace: A. A. Co Md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Benj S. Suit
13. Birthplace: A A Co Md

MOTHER
14. Maiden name: Ann S. Schuckell
15. Birthplace: A A Co Md.

16. Informant: Mrs Emma Burrough
Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 9-1947 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. Nov 9th 1947 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 6 1947, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1947 to Nov 6 1947 and that I last saw h.. alive on Nov 6 1947

Immediate cause of death	DURATION
Myocarditis Chronic	unkn.
Myocardial Insufficiency	
Due to: Arteriosclerosis	unkn.
Due to:	
Other conditions: Diabetes Mellitus	Years.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C Boyd M. D. or other
Address: Annapolis Md. Date signed: 11-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938

10525

Reg. Dist. No. 2 2

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessup (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 9-19-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town: no home (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Frank Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	unknown

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/9/81

8. AGE: Years	Months	Days	If less than one day
66	8	8	hrs. min.

9. Birthplace: Moorefield W. Va. (Town, county, and state)

10. Usual occupation: Stone Mason

11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace:

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Records of Md. House of Correction
Address: Jessup

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: Dec 1-47 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Jessup Md

18. Funeral director: H. L. Cookins.
Address: Jessup Md

19. Dec 1 1947 (Date rec'd by registrar) Clara Rasleff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 17 1947, at 3:40 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1947, to Nov 17 1947, and that I last saw him alive on Nov 16 1947

Immediate cause of death	DURATION
Cerebral Embolism	1 day
Due to: Chronic Myocarditis	7
Due to:	
Other conditions: Arteriosclerosis, Asthma, Dermatitis, Bedsores	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. LeRoy Wright M.D. or other

Address: Jessup Date signed: Nov 17 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09740

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: ANNE A RUNDEL

City or town: CROWNSVILLE
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos. 26 days

Hospital, institution, or street address where death occurred:
Crownsville, State Hospital

How long in hospital or institution? 4 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Cordova
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Box 69 Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: KENNETH WILSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): no record 1908

8. AGE: Years	Months	Days	If less than one day
39	?	?	____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: farm work

11. Industry or business:

FATHER
12. Name: Daniel Wilson
13. Birthplace: Maryland

MOTHER
14. Maiden name: unknown to us
15. Birthplace:

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/24/47 (month) (day) (year)

Cemetery or crematory: New Town
Location: Near Cordova, Md.

18. Funeral director: R. B. Rawlings
Address: Greensboro, Md.

19. 11/21/ 19 47 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 20, 1947 at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24, 1947 to November 20 1947 and that I last saw him alive on November 20, 1947

Immediate cause of death	DURATION
General Paresis	known to us since 6/24/47
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

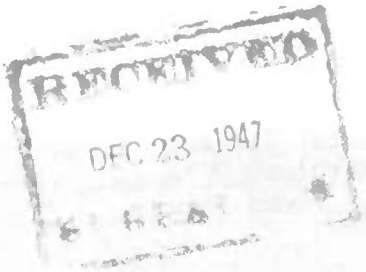
23. SIGNATURE: Jacob Hoffenstein M. D.
M. D. or other

Address: Crownsville, Md. Date signed: 11/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M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